IMITREX NASAL SPRAY 20MG/SPRAY / 1 spray intranasally prn
IMITREX 50MG TABLET / 1-2 tabs with onset of migrain
ASPIRIN 81MG TABLET EC / 1 po qd

Allergies:

Impression:
eruption of part of tooth
LSFT
HTN

Plan:
ORAL SURGERY CONSULT
ORTHOPEDIC CONSULT
FEMUR
TESTOSTERONE FREE AND TOTAL

Discontinued: VIOXX 50MG TABLET / 1 tab po qd

Refilled: VICODIN 5/500 TABLET / 1 tab po q 4 h prn

New medications: IBUPROFEN 600MG TABLET / 1 tab po tid

RTC

Keith Roach, MD

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

45104

CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
04/07/03 11:15

Progress Note: Steven Alfano / April 7, 2003

CIMA/GMC Preoperative Evaluation
Requested by: Dr Alexiades (fax 212-439-6855)
Referring Physician's address/telephone #: fax to Lenox Hill 434 3358
Planned surgery: labrectomy, arthroscopic
Surgery date: 4/16/03

HPI: 45 year old man with

PMH:
low back pain - on social security disability
taking Vioxx, Vicodin; off ibuprofen (headaches)

femur lesion - reassured by orthopaedic oncologist
dx LSMFT (? liposclerosing myxofibrous tumor)

depression - feeling better with benign diagnosis above
doing better with Wellbutrin

erectile dysfunction - also contributing to depression
got prescription

quit smoking

hernia
c/o pain under R testicle
worse after sex

HTN - on Zestril

Coronary artery disease: none
Diabetes mellitus requiring therapy other than diet: none
COPD: none
Asthma: none

PSH: hernia repair

Fhx: NC

Shx: living at home with wife
Work: on disability
Relationships:
Cigarette use: quit x 1 month
Alcohol: rare
Drugs:none

Health maintenance: up-to-date
Immunizations: up-to date

P. 1

x x x TRANSMISSION RESULT REPORT(IMMEDIATE TX) (AUG. 19. 2004 1:39PM) x x x

FAX HEADER: CIGNA DALLAS

DATE	TIME	ADDRESS	MODE	TIME	PAGE	RESULT	PERSONAL NAME	FILE
AUG. 19.	1:37PM	NYPH	G3ES	1'10"	P. 4	OK		334

:BATCH
M :MEMORY TX
S :STANDARD
x :PC

C :CONFIDENTIAL
L :SEND LATER
D :DETAIL
+ :ROUTING

$:TRANSFER
@ :FORWARDING
F :FINE
Q :RECEPT. NOTICE REQ.

P :POLLING
E :ECM
) :REDUCTION
A :RECEPT. NOTICE

Facsimile Transmission Cover Sheet

CIGNA Group Insurance
Life · Accident · Disability

Transmit to FAX number	Date	Time	Total number of pages (including this sheet):
212-746-8127	August 19, 2004	2:00 p.m.	4

Name Dr. Keith Roach	Name Mark Sodders
Company	Department CIGNA Disability Management Solutions
Phone 212-746-2879	Phone 1.800.352.0611 Extension 5693
Address 505 E. 70 St. HT. 450 New York, NY. 10021	Address 12225 Greenville Avenue Suite 1000, LB 179 Dallas Texas 75243

Comments

RE: Steven Alfano

DOB: 1/14/58

In order to evaluate your patient's eligibility for Long Term Disability benefits (e.g. lost wage income), we are in need of the following information:

- **A completed Physical Abilities Assessment form (attached).**
- **Copies of your progress notes, including diagnostic test and lab results, from 1/1/02 to the present.**

We ask that you kindly respond by **9/2/04** to avoid any delay in your patient's claim for lost wages.

Naturally, we will consider a reasonable charge for this medical information. Please include your **tax identification number.** If this request requires a pre-payment, please call me at the phone number above or fax (860.731.2907) a fee request to my attention.

Sincerely,

Mark Sodders
Case Manager

[ ] Acknowledgment Requested

To Fax a reply, dial : 860.731.2907

PHYSICAL ABILITY ASSESSMENT

We are evaluating your patient's disability claim in order to determine functional impairment Please check the boxes corresponding to the patient's level of physical functioning. **Please substantiate your findings with medical documentation. (Failure to provide the requested reports/data may result in delay in claim determinations).**

Patient Name_____ Date of Birth_____

Diagnosis(es)/ICD-9 Code_____

Throughout **an 8-hour workday, the patient can tolerate, *with positional changes and meal breaks*, the following activities for the specified durations:**

		Not applicable to diagnosis(es)	Continuously (67-100%) (5.5 + hrs)	Frequently (34-66%) (2.5 - 5.5 hrs)	Occasionally (1-33%) (<2.5 hrs)	Check if supported by objective findings
Sitting:						
Standing:						
Walking:						
Reaching:	Overhead					
	Desk Level Below Waist					
Fine Manipulation:	Right:					
	Left:					
Simple Grasp:	Right:					
	Left:					
Firm Grasp:	Right:					
	Left:					
Lifting:	10 lbs.					
	11-20 lbs.					
	21-50 lbs.					
	51-100 lbs.					
	100+ lbs.					
Carrying:	10 lbs.					
	11-20 lbs.					
	21-50 lbs.					
	51-100 lbs					
	100+ lbs.					

	Not applicable to diagnosis(es)	Continuously (67-100%) (5.5 + hrs)	Frequently (34-66%) (2.5 - 5.5 hrs)	Occasionally (1-33%) (<2.5 hrs)	Check if supported by objective findings
Pushing: (Max. Wt.:_____)					
Pulling: (Max. Wt.:_____)					
Climbing: Regular Stairs					
Regular Ladders					
Balancing:					
Stooping:					
Kneeling:					
Crouching:					
Crawling:					
Seeing:					
Hearing:					
Smell/Taste:					
Environmental Conditions: Exposure to extremes in heat					
Exposure to extremes in cold					
Exposure to wet / humid conditions					
Exposure to vibration					
Exposure to odors / fumes / particles					
Can work around machinery					
Ability to work extended shifts/ overtime:					
Use lower extremities for foot controls:					

Please use this space to elaborate on ANY of the above categories:

_____

_____

_____

_____

Name: _____ **Signature:** _____

Medical Specialty: _____ Date: _____

Address: _____ Phone: _____

Federal ID tax number: _____

Please include any objective test or narrative if available.
Thank you for your time.

Please return this form in the enclosed addressed envelope.

DISCLOSURE AUTHORIZAT

Claimant's Name (Please Print): STEVEN ALFANO

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give the company named below (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my plan administrator sponsors both a disability plan underwritten or administered by Company and a medical plan of any type written by another CIGNA company, the information and records described in this form may also be given to any CIGNA Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency insurance support organization, Claimant's agent, employer, group policyholder, business associate, benefit plan administrator, family members, friends, neighbors or associates, governmental agency including the Social Security Administration or any other organization or person having knowledge of me to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claim files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applie to future disclosures by writing the Company. The information obtained will not be disclosed to anyone EXCEPT: a)reinsuring companies; b)the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); c)fraud or overinsurance detection bureaus; d)anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in retur to employment discussions; e)for audit or statistical purposes; f)as may be required or permitted by law; g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drug or alcohol abuse, I understand that my records may be protecte under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, if I do so, Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

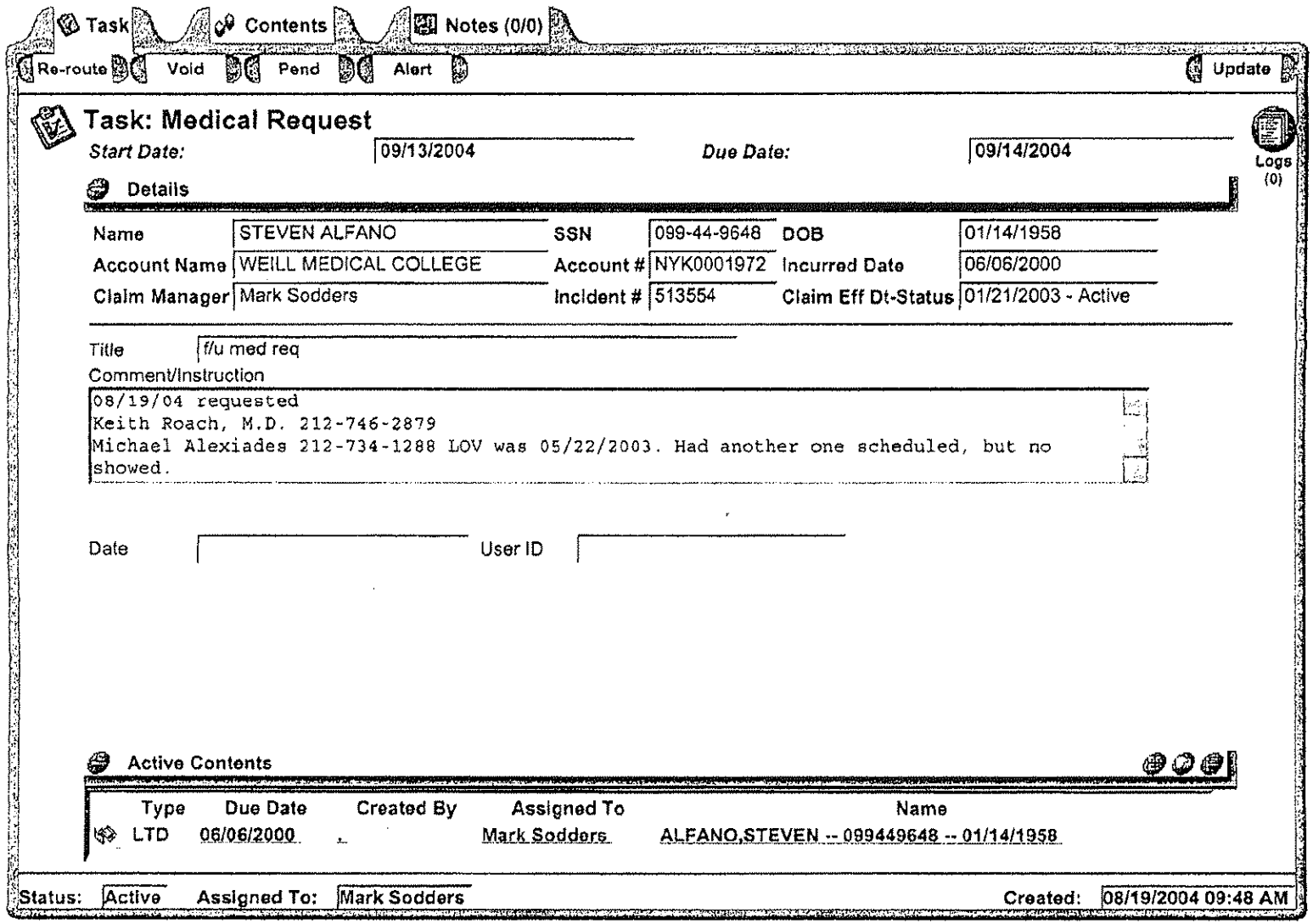
Signature of Claimant or
Claimant's Authorized Representative: [signature] Date: 7/20/04

Relationship,
if other than Claimant Claimant's Social Security Number: 096-44-9640

Company Name:

PROHIBITION ON RE-DISCLOSURE

If the medical information contains information regarding drug or alcohol abuse, it may be protected under federal law. Federa regulations (42 CFR Part 2) prohibit any person or entity who receives such protected information from the Company from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of such protected information to criminally investigate or prosecute any alcohol or drug abuse patient.



Task | Contents | Notes (0/0)

Re-route | Void | Pend | Alert | Update

Task: Medical Request

Logs (0)

Start Date: 09/13/2004 *Due Date:* 09/14/2004

Details

Name	STEVEN ALFANO	SSN	099-44-9648	DOB	01/14/1958
Account Name	WEILL MEDICAL COLLEGE	Account #	NYK0001972	Incurred Date	06/06/2000
Claim Manager	Mark Sodders	Incident #	513554	Claim Eff Dt-Status	01/21/2003 - Active

Title: f/u med req

Comment/Instruction:

08/19/04 requested
Keith Roach, M.D. 212-746-2879
Michael Alexiades 212-734-1288 LOV was 05/22/2003. Had another one scheduled, but no showed.

Date: | User ID:

Active Contents

Type	Due Date	Created By	Assigned To	Name
LTD	06/06/2000	,	Mark Sodders	ALFANO,STEVEN -- 099449648 -- 01/14/1958

Status: Active Assigned To: Mark Sodders Created: 08/19/2004 09:48 AM

Current Medications:

WELLBUTRIN SR 150MG TABLET / 1 tab po bid
VIAGRA 50MG TABLET / 1 tab po 1-2 h a intercourse
VICODIN 5/500 TABLET / 1 tab po q 4 h prn
TRIAMCINOLONE 0.1% CREAM / apply bid
CELEXA 20MG TABLET / 1 po qd
ZESTRIL 20MG TABLET / 1 po qd
PREVACID 30MG CAPSULES / 1 po qd
IMITREX NASAL SPRAY 20MG/SPRAY / 1 spray intranasally prn
IMITREX 50MG TABLET / 1-2 tabs with onset of migrain
ASPIRIN 81MG TABLET EC / 1 po qd
Allergies:

Review of Systems:
Problems with anesthesia: some difficulty last time with waking up after general anesthetic
Bleeding problems: none
Exercise:
Blocks walked before needing to rest: 1 block
Flights of steps climbed before needing to rest: 1
Reason for stopping: back pain, neuropathic pain in back/leg
Pulm: neg
Card: no chest discomfort
GI: neg
GU: neg

Objective:
healthy looking man in no distress
BP 130/100 P 100 bpm Wt 300 lbs Height 6ft 3in
HEENT: PERRL, EOMI w/out nystagmus, discs flat B, no H/E.
OP,TM's and nares clr, no sinus tenderness.
Neck: no LN, no thyromegaly/nodules, carotids 2+B, no bruits.
Lungs and Chest: CTA and P. No axillary or SC LN.
Cor: PMI nonenlarged, nondisplaced, RRR s1s2, no m/g/r.

Back: no spinous tenderness or scoliosis. No CVAT.
Abd: BS active, NT, ND, no HSM.
Rectal:
Lymphatics: No axillary, supraclavicular, or inguinal LAN.
Ext: DP 2+ B, no edema.
M/S:
Neuro: Nonfocal. Strength 5/5 B UE and LE. DTR's 2+ throughout.
Skin. No rashes or dysplastic nevi.
GU: testes NL size, no masses, no scrotal masses, no inguinal hernia B.

Data (as clinically indicated):
Chemistry battery:
Patient Name: ALFANO, STEVEN

CBC W/ DIFF & PLT			
WBC	8.6	Thous/mcL	3.8-10.8

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

45104

CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
04/07/03 11:15
Page 3

RBC	5.16	Mill/mcL	4.20-5.80
HEMOGLOBIN	15.3	g/dL	13.2-17.1
HEMATOCRIT	45.0	%	38.5-50.0
MCV	87.2	fL	80.0-100.0
MCH	29.6	pg	27.0-33.0
MCHC	33.9	g/dL	32.0-36.0
RDW	13.0	%	11.0-15.0
PLATELET COUNT	297	Thous/mcL	140-400
MPV	8.2	%	7.5-11.5
TOTAL NEUTROPHILS,%	66.9	%	38-80
TOTAL LYMPHOCYTES,%	24.2	%	15-49
MONOCYTES,%	6.8	%	0-13
EOSINOPHILS,%	1.8	%	0-8
BASOPHILS,%	0.3	%	0-2
NEUTROPHILS,ABSOLUTE	5753	Cells/mcL	1500-7800
LYMPHOCYTES,ABSOLUTE	2081	Cells/mcL	850-3900
MONOCYTES,ABSOLUTE	585	Cells/mcL	200-950
EOSINOPHILS,ABSOLUTE	155	Cells/mcL	15-550
BASOPHILS,ABSOLUTE	26	Cells/mcL	0-200
DIFFERENTIAL			

An instrument differential was performed.

COMP METABOLIC PANEL			
GLUCOSE,FASTING		mg/dL	65-109

Glucose was performed on the gray-top tube that we received with your chem-screen order. If you have any questions or concerns, please call our client services department at 800-631-1390.

SODIUM	142	mmol/L	135-146
POTASSIUM	4.6	mmol/L	3.5-5.3
CHLORIDE	103	mmol/L	98-110
CARBON DIOXIDE	25	mmol/L	21-33
UREA NITROGEN	18	mg/dL	7-25
CREATININE	1.1	mg/dL	0.5-1.4
BUN/CREATININE RATIO	16.4		6.0-25.0
CALCIUM	9.6	mg/dL	8.5-10.4
PROTEIN,TOTAL	7.5	g/dL	6.0-8.3
ALBUMIN	4.7	g/dL	3.5-4.9
GLOBULIN,CALCULATED	2.8	g/dL	2.2-4.2
A/G RATIO	1.7		0.8-2.0
BILIRUBIN,TOTAL	0.63	mg/dL	0.20-1.50
ALKALINE PHOSPHATASE	113	U/L	20-125
AST	23	U/L	2-50
ALT	33	U/L	2-60
PTT	30.0	Seconds	22.0-34.0
PROTHROMBIN TIME			
INR	0.95	Ratio	0.90-1.10

No Anticoagulant, Normal	0.9 - 1.1
Oral Anticoagulant, Standard Dose	2.0 - 3.0
Oral Anticoagulant, High Dose	2.5 - 3.5

URINALYSIS,COMPLETE			
COLOR	Dark Yellow		Yellow
APPEARANCE	Clear		Clear
GLUCOSE,QL	Negative	mg/dL	Negative
BILIRUBIN	Negative		Negative
KETONES	Negative	mg/dL	Negative
SPECIFIC GRAVITY	1.035 H		1.001-1.030

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

45104

CORNELL INTERNAL MEDICINE ASSOCIATES

BLOOD	Negative		Negative
PH	6.0		5.0-8.0
PROTEIN,TOTAL,QL	Trace	mg/dL	Negative
NITRITE	Negative		Negative
LEUKOCYTE ESTERASE	Negative		Negative
SQUAMOUS EPITHELIAL CELLS	None	/hpf	0-5
WBC	None	/hpf	0-3
BACTERIA	None	/hpf	None
RBC	None	/hpf	0-2
GLUCOSE	96	mg/dL	65-125

The glucose reference range is based on a non-fasting state.

CBC:
PT/PTT:
ECG: normal
Chest X-ray: 2002 normal, not indicated today
Stress test: not indicated

Impression:
low risk for planned surgery
HTN - well controlled
back pain - OK on analgesics
ibuprofen d/c'd
hold aspirin starting today

Recommendations:
no medical contraindications to planned surgery

Keith Roach, MD

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

45104

CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
04/07/03 11:41

Patient Name: ALFANO, STEVEN
History #: 2284147
Accession #: 28446202
Soc Security: 099449648
Date of Birth: 01/14/58
Sex: M
Ordered by:
Specimen Date: 04/07/2003 11:41
Report Date: 04/08/2003 04:35
Status: Final

CBC W/ DIFF & PLT

WBC	8.6	Thous/mcL	3.8-10.8
RBC	5.16	Mill/mcL	4.20-5.80
HEMOGLOBIN	15.3	g/dL	13.2-17.1
HEMATOCRIT	45.0	%	38.5-50.0
MCV	87.2	fL	80.0-100.0
MCH	29.6	pg	27.0-33.0
MCHC	33.9	g/dL	32.0-36.0
RDW	13.0	%	11.0-15.0
PLATELET COUNT	297	Thous/mcL	140-400
MPV	8.2	%	7.5-11.5
TOTAL NEUTROPHILS,%	66.9	%	38-80
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MONOCYTES,%	6.8	%	0-13
EOSINOPHILS,%	1.8	%	0-8
BASOPHILS,%	0.3	%	0-2
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LYMPHOCYTES,ABSOLUTE	2081	Cells/mcL	850-3900
MONOCYTES,ABSOLUTE	585	Cells/mcL	200-950
EOSINOPHILS,ABSOLUTE	155	Cells/mcL	15-550
BASOPHILS,ABSOLUTE	26	Cells/mcL	0-200

DIFFERENTIAL
An instrument differential was performed.

COMP METABOLIC PANEL

GLUCOSE,FASTING		mg/dL	65-109

Glucose was performed on the gray-top tube that we received with your chem-screen order. If you have any questions or concerns, please call our client services department at 800-631-1390.

SODIUM	142	mmol/L	135-146
POTASSIUM	4.6	mmol/L	3.5-5.3
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CARBON DIOXIDE	25	mmol/L	21-33
UREA NITROGEN	18	mg/dL	7-25
CREATININE	1.1	mg/dL	0.5-1.4
BUN/CREATININE RATIO	16.4		6.0-25.0
CALCIUM	9.6	mg/dL	8.5-10.4
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A/G RATIO	1.7		0.8-2.0
BILIRUBIN,TOTAL	0.63	mg/dL	0.20-1.50
ALKALINE PHOSPHATASE	113	U/L	20-125
AST	23	U/L	2-50
ALT	33	U/L	2-60

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

45104

CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
04/07/03 11:41
Page 2

PTT	30.0	Seconds	22.0-34.0
PROTHROMBIN TIME			
INR	0.95	Ratio	0.90-1.10
No Anticoagulant, Normal			0.9 - 1.1
Oral Anticoagulant, Standard Dose			2.0 - 3.0
Oral Anticoagulant, High Dose			2.5 - 3.5

URINALYSIS,COMPLETE			
COLOR	Dark Yellow		Yellow
APPEARANCE	Clear		Clear
GLUCOSE,QL	Negative	mg/dL	Negative
BILIRUBIN	Negative		Negative
KETONES	Negative	mg/dL	Negative
SPECIFIC GRAVITY	1.035 H		1.001-1.030
BLOOD	Negative		Negative
PH	6.0		5.0-8.0
PROTEIN,TOTAL,QL	Trace	mg/dL	Negative
NITRITE	Negative		Negative
LEUKOCYTE ESTERASE	Negative		Negative
SQUAMOUS EPITHELIAL CELLS	None	/hpf	0-5
WBC	None	/hpf	0-3
BACTERIA	None	/hpf	None
RBC	None	/hpf	0-2
GLUCOSE	96	mg/dL	65-125

The glucose reference range is based on a non-fasting state.

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

45104

CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
05/01/03 11:23

Mt Sinai School Of Medicine

January 224th 2003

Dr. Dempsey S. Sprinfield, MD
Orthopaedic Surgeon
212-241-8311
fax # 212-534-6145

DX: LSMFT

Impression:
Left hip remains the same with an occasional discomfort. He has no limp and he functions well. He has more difficulty with his right hip and has decided to have the labral tear repaired.

AP and lateral x-rays today show no change in the lesion in the proximal intertrochanteric and subtrochateric areas with radiolucencies and readiodensities. I compared it to the one taken in July.

ms

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

45104

CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
05/21/03 22:09

Progress Note: Steven Alfano / May 21, 2003

Subjective: 45 year old man with skin tage
for removal

surgery for torn labrum went well

back pain - considering surgery
one problem at a time!

quit smoking

forms filled out

Objective:

BP 130/90 P 80 bpm RR 12 Temp 99.1 f Wt 294 lbs Height 6ft 3in Pain usual
multiple skin tags

Current Medications:

WELLBUTRIN SR 150MG TABLET / 1 tab po bid
VIAGRA 50MG TABLET / 1 tab po 1-2 h a intercourse
VICODIN 5/500 TABLET / 1 tab po q 4 h prn
TRIAMCINOLONE 0.1% CREAM / apply bid
CELEXA 20MG TABLET / 1 po qd
ZESTRIL 20MG TABLET / 1 po qd
PREVACID 30MG CAPSULES / 1 po qd
IMITREX NASAL SPRAY 20MG/SPRAY / 1 spray intranasally prn
IMITREX 50MG TABLET / 1-2 tabs with onset of migrain
ASPIRIN 81MG TABLET EC / 1 po qd

Allergies:

Impression:

Plan:
removed with sterile scisors without lidocaine per pt request

discussed options for back pain

RTC 3 mo

Keith Roach, MD
Electronic Signature on File

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

45104

CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
09/22/03 10:01

Progress Note: Steven Alfano / September 22, 2003

Subjective: 45 year old man with
quit smoking

lost 4 lb

musculoskeletal
R hip - will see Alexiades
neck - C5 stenosis
shoulder - fixed!

sleep apnea

concern about CAD

skin tag

Objective:

BP 110/80 P 80 bpm RR 12 Temp 98.2 f Wt 290lbs] Height 6ft 3in
looks well
small, benign appearing skin tags

Current Medications:

WELLBUTRIN SR 150MG TABLET / 1 tab po bid
VIAGRA 50MG TABLET / 1 tab po 1-2 h a intercourse
VICODIN 5/500 TABLET / 1 tab po q 4 h prn
TRIAMCINOLONE 0.1% CREAM / apply bid
CELEXA 20MG TABLET / 1 po qd
ZESTRIL 20MG TABLET / 1 po qd
PREVACID 30MG CAPSULES / 1 po qd
IMITREX NASAL SPRAY 20MG/SPRAY / 1 spray intranasally prn
IMITREX 50MG TABLET / 1-2 tabs with onset of migrain
ASPIRIN 81MG TABLET EC / 1 po qd
OXYCONTIN 10MG TABLETS / 1 tab po q6 h

Allergies:

Impression:

Plan:
smoking - congratulations

hip pain - will f/u Dr Alexaides

spinal stenosis - refilled narcotics - pt to revisit more aggressive treatment
has lost weight

sleep apnea - no evidence end-organ damage, no daytime somnolence - no need for CPAP at this time

? CAD - recheck labs

RTC

Keith Roach, MD
Electronic Signature on File

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

45104

CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
09/22/03 22:10

Patient Name: ALFANO, STEVEN
History #: 2284147
Accession #: 70479879
Soc Security: 099449648
Date of Birth: 01/14/58
Sex: M
Ordered by: ROACH,KEITH
Specimen Date: 09/22/2003 22:10
Report Date: 09/23/2003 06:37
Status: Final

LIPID PANEL			
TRIGLYCERIDES	130	mg/dL	<150
HDL CHOLESTEROL	46	mg/dL	>/=40
CHOLESTEROL,TOTAL	224 H	mg/dL	<200
HDL CHOLESTEROL	46	mg/dL	>/=40
CHOLESTEROL/HDL RATIO	4.9		<5.0
LDL CHOL, CALCULATED	152 H	mg/dL	<130
TRIGLYCERIDES	130	mg/dL	<150
COMP METABOLIC PANEL			
GLUCOSE	69	mg/dL	65-125

The glucose reference range is based on a non-fasting state.

SODIUM	141	mmol/L	135-146
POTASSIUM	4.4	mmol/L	3.5-5.3
CHLORIDE	102	mmol/L	98-110
CARBON DIOXIDE	26	mmol/L	21-33
UREA NITROGEN	20	mg/dL	7-25
CREATININE	1.0	mg/dL	0.5-1.4
BUN/CREATININE RATIO	20.0		6.0-25.0
CALCIUM	9.4	mg/dL	8.5-10.4
PROTEIN,TOTAL	7.4	g/dL	6.0-8.3
ALBUMIN	4.7	g/dL	3.5-4.9
GLOBULIN,CALCULATED	2.7	g/dL	2.2-4.2
A/G RATIO	1.7		0.8-2.0
BILIRUBIN,TOTAL	0.66	mg/dL	0.20-1.50
ALKALINE PHOSPHATASE	118	U/L	20-125
AST	21	U/L	2-50
ALT	32	U/L	2-60
C-REACTIVE PROTEIN			
C-REACTIVE PROTEIN	0.1	mg/dL	<0.8

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

45104

CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
01/22/04 15:42

Mt Sinai School of Medicine

IMPRESSION:

Mr. ALfano remains asymptomatic . X-rays show no change in the ledsion in his proximal femur. We will follow him on and annual basis.

Dempsey S. Sprinfield, MD

ms

FRAUD WARNING: Any person who, knowingly and with intent to defraud any insurance company or other person, (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. For residents of the following states, please see the reverse side of this form: *California, Colorado, District of Columbia, Florida, Maryland, New Jersey, New York, Pennsylvania, Oregon or Virginia.*

Name:	Social Security No.:
STEVEN ALFANO	099-44-9648
Address: 3200 WALDO AVE BRONX, NY 10463	**Telephone No.:** 718 884 2067

1. In your own words, tell us why you cannot work in your own or in any occupation.
CONSTANT BACK/LEG PAIN PREVENTS CONCENTRATION ON MENTAL TASKS. CONDITION IS MADE WORSE BY SITTING, STANDING OR WALKING. SITTING ESPECIALLY PRODUCES PAIN AND NUMBNESS IN BACK, BUTTOCKS, LEGS AND FEET.

2. What is primary physical and/or mental condition preventing you from working now?
SAME AS ABOVE ANSWER TO QUES 1. PLUS I MUST LIE DOWN FREQUENTLY THROUGH THE DAY FOR 1-2 HOURS AT A TIME. THIS FORM TOOK ME 3 SITTINGS TO COMPLETE.

3. Can you drive? ☑ Yes ☐ No How far? 10 MILES OR UP TO 30 MINUTES.

4. What time do you get up in the morning? 6 AM What time do you go to bed? 11:30 PM

5. Where do you live? ☑ Apartment ☐ House
How many floors in the apartment/house? 20 Does it have an elevator? ☑ Yes ☐ No
Do you use any special equipment - ramps, handrails, wheelchair? ☑ Yes ☐ No
If yes, describe HANDRAILS, USE CANE FOR BALANCE/SUPPORT

6. Do you own a personal computer? ☑ Yes ☐ No
Is it connected to the Internet? ☑ Yes ☐ No
What computer programs or software can you use? EMAIL
How often do you use the computer? EVERY OTHER DAY OR SO

7. Check the things you do regularly:

Activity	Hours per day?	Days per week?
☐ Cook		
☐ Clean		
☐ Shop		
☐ Laundry		
☐ Yardwork		
☐ Gardening		
☐ Read		
☑ Watch TV	3	5
☐ Other (school, attend religious services, volunteer work, etc.)		

What do you do for recreation? LISTEN TO MUSIC, WATCH BASEBALL OR TV. LAY IN SUN.

8. Are there things you attend to with regard to your personal needs (grooming, dressing, etc.)?
I MUST TAKE LONG HOT BATHS DAILY TO EASE STIFFNESS, I SHAVE OCCASIONALLY BUT NOW MUST USE AN ELECTRIC RAZOR SO I DON'T HAVE TO BEND OVER THE SINK.

GB-609428 (10/2003)

Disability Questionnaire & Activities of Daily Living

CIGNA-0343
5.32.01

CIGNA Group Insurance
Life • Accident • Disability
Connecticut General Life Insurance Company
Insurance Company of North America
CIGNA Life Insurance Company of New York

GB-609428 (10/2003)

9. Do you go for walks? ☐ Yes ☑ No How often? _____
How far do you walk? _____ For how long? _____

10. Do you engage in a regular exercise program? ☐ Yes ☑ No
Where (home, gym, etc.) _____
How often? _____
Describe your exercise program _____

11. Please circle the highest grade you completed in school:

1 2 3 4 5 6 7 8 9 10 11 12 GED High School Diploma

College? 1 yr. 2 yrs. 3 yrs. 4 yrs. (BA/BS Degree) Masters Degree Other

Type of degree? (Business, History, Social Sciences, etc.) BUSINESS
Date Received 2/82
List any professional/educational certificates, licenses, etc. awarded N/A
List any vocational programs you have attended/completed N/A
In the last 3 years, what type of certificates or licenses have you received? _____

12. Are you taking any professional/educational/vocational classes now? ☐ Yes ☑ No
Please list them _____

13. Are you working? ☐ Yes ☑ No
If so, please list how many hours per day you work, and the name of your employer. _____

Employment History

1. Job Title: WAGE & SALARY MGR	Employed date: From: 5/91 Through: 6/00
Major Duties: DEVELOP AND ADMINISTER COMPENSATION SYSTEMS, NEGOTIATE SALARIES.	Minor Duties: ADMINISTER PERFORMANCE EVALUATION SYSTEMS. APPROVE JOB DESCRIPTIONS
Tools/Equipment used: COMPUTER, CALCULATOR	Machinery/Computers used: PC, MAINFRAME
2. Job Title: ASST. DIR. HUMAN RESOURCES	Employed date: From: 3/90 Through: 11/90
Major Duties: ADMINISTERED COMPENSATION AND EMPLOYMENT FUNCTIONS.	Minor Duties: ADMINISTER EMPLOYEE IMIGRATION, HOUSING AND ORIENTATION PROGRAMS
Tools/Equipment used: CALCULATOR	Machinery/Computers used: PC
3. Job Title: WAGE & SALARY ANALYST/MGR	Employed date: From: 6/82 Through: 2/90
Major Duties: ADMINISTRATION OF WAGES AND SALARIES	Minor Duties: LABOR RELATIONS
Tools/Equipment used: CALCULATOR	Machinery/Computers used: PC

14. Have you ever owned or operated your own business? ☐ Yes ☑ No
Do you own, operate or have ownership interest in a business now? ☐ Yes ☑ No
Business Name _____
Address _____
City _____
Telephone Number ( ) _____
Date business began _____
Describe the business _____

IMPORTANT CLAIM NOTICE

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Maryland Residents: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

Oregon Residents: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania Residents: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits applicaiton or files a claim containing a false or deceptive statement may have violated state law.

15. Are you married? ☑ Yes ☐ No
If yes, please provide: Spouse's Name: EVA ALFAND DOB: 5/25/62
Spouse's SSN: 060-65-9638

Do you have any children under age 18? ☑ Yes ☐ No
Please list their names and dates of birth in order:
ANDREA ALFAND 10/1/92
MICHAEL ALFAND 5/18/95

Do you have any handicapped children over 18? ☐ Yes ☑ No

16. List any prescription medications you take: Use other side if you need more space.

Medication	Dose	Frequency	Medication	Dose	Frequency
OXYCONTIN	40MG	4-6/DAY	PREVACID	30MG	1/DAY
VIOXX	50MG	1/DAY			
ZESTRIL	20MG	1/DAY			

17. List any doctor(s) you see regularly. Use the other side if you need more room.

Doctor's Name/Speciality:		Doctor's Name/Speciality:	
KEITH ROACH / INTERNAL MEDICINE		MICHAEL ALEXIADES / ORTHOPEDIC SURGERY	
Address: 505 E. 70 ST. / HT 450 NY NY 10021		Address: 159 E. 74 ST NY NY 10021	
Telephone #: 212-746-2879	Fax #: 212-746-8127	Telephone #: 212-734-1288	Fax #: 212-439-6855
Frequency of visits: 3-6 MOS.	Date of last visit: 7/20/04	Frequency of visits: 6-12 MOS	Date of last visit: 9/03
Doctor's Name/Speciality:		Doctor's Name/Speciality:	
Address:		Address:	
Telephone #:	Fax #:	Telephone #:	Fax #:
Frequency of visits:	Date of last visit:	Frequency of visits:	Date of last visit:

18. Are you right handed or left handed? ☐ Right ☑ Left
What is your height? 6'3" What is your date of birth? 1/14/58
What is your weight? 280 LBS

19. Are you a veteran? ☐ Yes ☑ No
If yes, have you applied for VA benefits for this disability? ☐ Yes ☐ No
Please attach a copy of your VA disability award.

20. What other types of income/money/compensation/benefits are you receiving or eligible to receive?

			$ Amount/Frequency	Date Began	Date Paid Through
☐ Yes	☑ No	Salary Continuance			
☐ Yes	☑ No	State Disability Benefits			
☐ Yes	☑ No	Group Disability Benefits			
☐ Yes	☑ No	Workers' Compensation			
☐ Yes	☑ No	Pension Benefits			
☐ Yes	☑ No	No-Fault Auto Disability Insurance			
☑ Yes	☐ No	Any Other Disability Income - SOCIAL SECURITY DBL	$1591/MO	6/2000	ON-GOING

I certify that the information in this document is true and correct.

Signature _____ Date 7/20/04

DISCLOSURE AUTHORIZATION

Claimant's Name (Please Print): STEVEN ALFAND

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give the company named below (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my plan administrator sponsors both a disability plan underwritten or administered by Company and a medical plan of any type written by another CIGNA company, the information and records described in this form may also be given to any CIGNA Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, business associate, benefit plan administrator, family members, friends, neighbors or associates, governmental agency including the Social Security Administration or any other organization or person having knowledge of me to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claim files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures by writing the Company. The information obtained will not be disclosed to anyone EXCEPT: a)reinsuring companies; b)the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); c)fraud or overinsurance detection bureaus; d)anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; e)for audit or statistical purposes; f)as may be required or permitted by law; g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drug or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, if I do so, Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or
Claimant's Authorized Representative: [signature] Date: 7/20/04

Relationship,
if other than Claimant: ENE-DOT Claimant's Social Security Number: 099-44-9640

Company Name:

L.S.D.

PROHIBITION ON RE-DISCLOSURE

If the medical information contains information regarding drug or alcohol abuse, it may be protected under federal law. Federal regulations (42 CFR Part 2) prohibit any person or entity who receives such protected information from the Company from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of such protected information to criminally investigate or prosecute any alcohol or drug abuse patient.

[redacted] [redacted]

2:00 pm (212) 746-3801 - med. records

Called Dr. Roach's office. Left message with medical records dept. Asked that they call me back w/ status of our request.

KAE 9/5/03